Complete Summary

GUIDELINE TITLE

2002 national guideline for the management of prostatitis.

BIBLIOGRAPHIC SOURCE(S)

Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD). 2002 national guideline for the management of prostatitis. London: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD); 2002. Various p. [93 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Acute prostatitis
- Chronic prostatitis, differentiated as:
  - Chronic bacterial prostatitis
  - Chronic abacterial prostatitis/chronic pelvic pain syndrome-inflammatory (previously called chronic non-bacterial prostatitis)
  - Chronic abacterial prostatitis/chronic pelvic pain syndrome-non-inflammatory (previously called prostatodynia)

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Infectious Diseases
Urology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To present a national guideline for the management of acute and chronic prostatitis

TARGET POPULATION

Men in the United Kingdom with prostatitis

INTERVENTIONS AND PRACTICES CONSIDERED

Assessment/Diagnosis of Acute Prostatitis

1. Assessment of clinical features
2. Diagnostic techniques
    - Mid-stream urine sample for dipstick testing, culture for bacteria, and antibiotic sensitivity
    - Blood cultures for bacteria and antibiotic sensitivity

Note: Prostatic massage is considered but not recommended for acute prostatitis

Assessment/Diagnosis of Chronic Prostatitis

1. Assessment of clinical features
2. Diagnostic techniques
    - Urinary tract localisation procedure
    - Prostatic massage
    - Urine sample collection: first void urethral urine; mid-stream bladder urine; post-prostatic massage
    - Urine microscopy and quantitative culture.
    - Collection of expressed prostatic secretions followed by a wet preparation microscopic examination and test of pH
    - A serum prostate specific antigen measurement (in men over 45 years)

Note: Transrectal ultrasound is considered but not recommended to differentiate the different forms of chronic prostatitis. Urinary tract localisation procedure is often not used in clinical practice.

Management/Treatment of Acute Prostatitis

1. Hydration
2. Rest

3. Empirical therapy
4. Suprapubic catheterisation if catheterisation needed
5. Pharmacotherapy
    - Analgesics, such as non-steroidal anti-inflammatory drugs
    - For patients requiring parenteral therapy antibiotics covering the likely organisms: broad spectrum cephalosporins, for example, cefuroxime, cefotaxime, or ceftriaxone plus gentamicin
    - Oral treatment according to sensitivities
    - Quinolones, such as ciprofloxacin or ofloxacin
    - For patients intolerant of, or allergic to, quinolones: co-trimoxazole; trimethoprim
6. Follow-up
    - If failure to respond to therapy, evaluation for prostatic abscess using a transrectal ultrasound scan or computed tomography scan of the prostate gland; if needed, perineal or transurethral drainage
    - At least 4 weeks of antibiotic therapy is recommended in all patients to try to prevent chronic bacterial prostatitis
    - Following resolution of acute prostatitis the urinary tract should be investigated for any structural problems.

Management/Treatment of Chronic Prostatitis

1. Oral and written patient education
2. Pharmacological treatment for chronic bacterial prostatitis chosen according to antimicrobial sensitivities
    - Quinolones, such as: ciprofloxacin; ofloxacin; norfloxacin
    - For those allergic to quinolones: minocycline; doxycycline; trimethoprim; co-trimoxazole
    - Other treatments for chronic bacterial prostatitis: radical transurethral prostatectomy or total prostatectomy in carefully selected patients.
3. Treatment for chronic abacterial prostatitis by trial and error:
    - Treat as for chronic bacterial prostatitis with a quinolone or tetracycline
    - Transurethral microwave thermotherapy
    - Alpha Blockers: terazosin, alfuzosin
    - Non-steroidal anti-inflammatory drugs
    - Cernilton (pollen extract)
    - Bioflavonoid quercetin
    - Stress management. Referral for psychological assessment as appropriate; diazepam. Note: benzodiazepines are considered but not recommended in clinical practice because of dependency
4. Follow-up

    Note: allopurinol (chronic abacterial prostatitis) is considered but further studies are needed before recommending it.

MAJOR OUTCOMES CONSIDERED

- Efficacy of treatment
- Prevention rates of chronic prostatitis in men who have been treated for acute prostatitis

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The guideline developers searched Medline from 1966-2000 using the keyword "prostatitis." Cochrane Database of Systematic Reviews and the Cochrane Controlled Trials Register were searched up to 2000 using the keyword "prostatitis." Further references from articles identified by Medline were included.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence:

Ia

- Evidence obtained from meta-analysis of randomised controlled trials

Ib

- Evidence obtained from at least one randomised controlled trial

IIa

- Evidence obtained from at least one well designed controlled study without randomisation

IIb

- Evidence obtained from at least one other type of well designed quasi-experimental study

III

- Evidence obtained from well designed non-experimental descriptive studies such as comparative studies, correlation studies, and case control studies

IV

- Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The revision process commenced with authors being invited to modify and update their 1999 guidelines. These revised versions were posted on the website for a 3 month period and comments invited. The Clinical Effectiveness Group and the authors concerned considered all suggestions and agreed on any modifications to be made.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grading of Recommendations:

A (Evidence Levels Ia, Ib)

- Requires at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing the specific recommendation.

B (Evidence Levels IIa, IIb, III)

- Requires availability of well conducted clinical studies but no randomised clinical trials on the topic of recommendation.

C (Evidence Level IV)

- Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities.
- Indicates absence of directly applicable studies of good quality.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The initial versions of the guidelines were sent for review to the following:

- Clinical Effectiveness Group (CEG) members
- Chairs of UK Regional GU Medicine Audit Committees who had responded to an invitation to comment on them
- Chair of the Genitourinary Nurses Association (GUNA)
- President of the Society of Health Advisers in Sexually Transmitted Diseases (SHASTD)
- Clinical Effectiveness Committee of the Faculty of Family Planning and Reproductive Health Care (FFP)

Comments were relayed to the authors and attempts made to reach a consensus on points of contention with ultimate editorial control resting with the Clinical Effectiveness Group. Finally, all the guidelines were ratified by the councils of the two parent societies.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Levels of evidence (I-IV) and grades of recommendation (A-C) are defined at the end of the "Major Recommendations" field.

Diagnosis of Acute Prostatitis

- Mid-stream urine sample for dipstick testing, culture for bacteria, and antibiotic sensitivity
- Blood cultures for bacteria and antibiotic sensitivity
- Prostatic massage should not be performed on patients with acute bacterial prostatitis. This would be extremely painful, could precipitate bacteraemia, and is likely to be of little benefit as pathogens are almost always isolated from urine

Management of Acute Prostatitis

<u>General advice</u>

Adequate hydration should be maintained, rest encouraged, and analgesics such as non-steroidal anti-inflammatory drugs used.

Treatment

- As acute prostatitis is a serious and severe illness, empirical therapy should be started immediately.
- Parenteral or oral treatment should be selected according to the clinical condition of the patient. If there is deterioration or failure to respond to oral therapy, urgent admission and parenteral therapy should be arranged.
- Good antibiotic penetration into all areas of the prostate gland is achieved because of the intense inflammation.
- Antibiotics should be continued or changed according to sensitivity results.
- If acute retention occurs, suprapubic catheterisation should be performed to avoid damage to the prostate (Luzzi, 1996; Meares, 1987).

Recommended regimens

For patients requiring parenteral therapy, antibiotics covering the likely organisms should be used (Katoh et al., 1992):

- A high dose broad spectrum cephalosporin--for example, cefuroxime, cefotaxime, or ceftriaxone plus gentamicin (Level of Evidence IV, Grade of Recommendation C)
- When clinically improved, the therapy can be switched to oral treatment according to sensitivities.

For patients suitable for oral therapy, quinolones can be used: (Arakawda et al., 1994; Andriole, 1991)

- Ciprofloxacin 500 mg twice daily for 28 days (Level of Evidence IV, Grade of Recommendation C) (Andriole, 1991; Naber, 1991)

  OR

- Ofloxacin 200 mg twice daily for 28 days (Level of Evidence IV, Grade of Recommendation C) (Suzuki et al., 1984; Remy et al., 1988)

Allergy

For patients intolerant of, or allergic to, quinolones, an alternative is:

- Co-trimoxazole (TMP-SMX) 960 mg twice daily for 28 days (Meares, 1987)
  OR
- Trimethoprim 200 mg twice daily for 28 days (Level of Evidence IV, Grade of Recommendation C)

Sexual partners

Treatment of sexual partners is not required as the condition is caused by uropathogens.

Follow-up

- If the patient fails to respond fully to therapy the diagnosis of a prostatic abscess should be considered (Meares, 1986). This can be confirmed by transrectal ultrasound scan or computed tomography scan of the prostate gland. If present, perineal or transurethral drainage will be necessary (Meares, 1987).
- If acute prostatitis is managed correctly, the prognosis is good and cure likely. At least 4 weeks of antibiotic therapy is recommended in all patients to try to prevent chronic bacterial prostatitis (Meares, 1987).
- When the patient has recovered, his urinary tract should be investigated to exclude a structural cause for urinary tract infection (Luzzi, 1996).

Diagnosis of Chronic Prostatitis

Strictly, symptoms should have been present for at least 6 months to diagnose chronic prostatitis although in practice the diagnosis is made after a shorter duration of symptoms.

Non-specific genital infection can cause many of the same symptoms and this diagnosis should be considered and excluded.

The investigation of chronic prostatitis which has been the standard for evidence based research is the lower urinary tract localisation procedure (Meares & Stamey, 1968). Although time consuming, this is the most accurate method for differentiating chronic bacterial prostatitis, chronic abacterial prostatitis/chronic pelvic pain syndrome-inflammatory, and chronic abacterial prostatitis/chronic pelvic pain syndrome-non-inflammatory (Nickel, 1998; Drach et al., 1978).

Some authors argue that the lower urinary tract localisation procedure should be confined to research (Berger et al., 1989). It is useful in diagnosing chronic bacterial prostatitis but it is often not used in clinical practice and may not alter patient management (McNaughton Collins et al., 2000).

When the patient attends for prostatic massage:

- No antibiotics should have been taken for 1 month (Bergman, Wedren, & Holm, 1989)
- The patient should not have ejaculated for 2 days
- The patient should have a full but not distended bladder (Luzzi, 1996; Jameson, 1967)

Prostatic massage should not be performed if there is evidence of urethritis or urinary tract infection. If either of these is present they should first be treated to prevent prostatic secretion contamination (Thin, 1997; Simmons & Thin, 1983; Nickel, 1996).

Prostatic massage

- The foreskin should be fully retracted and the penis well cleaned to prevent contamination.

- A 5 to 10 mL sample of first void urethral urine should be collected.
- The patient should urinate a further 100 to 200 mL urine and then a further 5 to 10 mL sample of mid-stream bladder urine should be collected.
- By digital rectal examination a vigorous massage of the prostate gland should be performed for 1 minute, from periphery towards the midline with a sterile container held over the glans to collect any expressed prostatic secretions.
- A wet preparation microscopic examination of a sample of expressed prostatic secretions should be made to determine the number of polymorphonuclear leucocytes per high power field (x 400) (Bergman, Wedren, & Holm, 1989; Simmons & Thin, 1983).
- Immediately after the massage another 5 to 10 mL post-massage urine should be collected.
- All three urine samples should have microscopy and quantitative culture.

A dry prostatic massage is reasonably common.

Other possible investigations

- The presence of clumps of polymorphonuclear leucocytes (5+) and oval fat bodies (macrophages containing fat droplets) can be noted on wet preparation examination (Oates, 1969; Thin, 1991).
- The pH of expressed prostatic secretions increases with prostatitis and a pH greater than or equal to 8 indicates likely prostatitis, but this should only be used in conjunction with the other tests detailed above (Thin, 1991).
- Transrectal ultrasound in chronic prostatitis may identify those who have cysts or abscesses suitable for aspiration and are likely to experience relief of symptoms (Thin, 1997). Transrectal ultrasound should not be used to differentiate the different forms of chronic prostatitis (Ludwig et al., 1994).
- A serum prostate-specific antigen should be measured in men over 45 years (Luzzi, 1996), although it will probably be above normal in men with prostatic inflammation (Nadler et al., 1995).

Interpretation of results

- To assign an organism to the prostate, the colony count in the expressed prostatic secretions and post-massage urine is required to be at least 10 times greater than in first void urethral urine and mid-stream bladder urine.
- For prostatic inflammation $\geq$10 polymorphonuclear leucocytes/high power field (hpf) is considered diagnostic (Wright et al., 1994; Doble, 1994; Anderson & Weller, 1979; Weidner, 1992). In cases of a dry expressate a polymorphonuclear leucocyte count of 10/hpf greater in post-massage urine than first void urethral urine and mid-stream bladder urine is diagnostic of prostatitis.
- If there is significant bacteriuria in both mid-stream bladder urine and post-massage urine 3 days of nitrofurantoin 50 mg four times daily, which is not prostate penetrating, should be given and the procedure then repeated.
- An expressed prostatic secretion pH $\geq$8 suggests prostatitis although it is not diagnostic.
- Clumping of polymorphonuclear leucocytes and presence of lipid laden macrophages suggests prostatitis, although this is not diagnostic.

General advice

Patients should be given a detailed explanation of their condition with particular emphasis on the long-term implications for their health. This should be reinforced by giving them clear and accurate written information.

Treatment for chronic bacterial prostatitis

Many antimicrobials penetrate the prostate gland poorly. In chronic bacterial prostatitis the gland is either subacutely inflamed or non-inflamed.

Treatment should be chosen according to antimicrobial sensitivities.

Recommended regimens

For patients with chronic bacterial prostatitis, first line treatment is with a quinolone such as (Andriole, 1991; Naber, 1991):

- Ciprofloxacin 500 mg twice daily for 28 days (Level of Evidence III, Grade of Recommendation B) (Weidner, Schiefer, & Dalhoff, 1987; Childs, 1987; Weidner, Schiefer, & Brahler, 1991)

  OR

- Ofloxacin 200 mg twice daily for 28 days (Level of Evidence III, Grade of Recommendation B) (Remy et al., 1988; Koff, 1996)

  OR

- Norfloxacin 400 mg twice daily for 28 days (Level of Evidence III, Grade of Recommendation B) (Sabbaj, Hoagland, & Cook, 1986; Schaeffer & Darras, 1990)

Allergy

For those allergic to quinolones, the following is recommended:

- Minocycline 100 mg twice daily for 28 days (Paulson & White, 1978) (Level of Evidence III, Grade of Recommendation B) (In practice most experts would use doxycycline 100 mg twice daily for 28 days because of more toxicity with minocycline.)

  OR

- Trimethoprim 200 mg twice daily for 28 days

  OR

- Co-trimoxazole (TMP-SMX) 960 mg twice daily for 28 days (Level of Evidence III, Grade of Recommendation B) (Naber, 1991).

If minocycline is used, antibiotic sensitivity testing is essential as many urinary pathogens are tetracycline resistant. Many studies using trimethoprim or co-trimoxazole have used 90 days treatment (Naber, 1991).

Some studies have looked at longer treatment periods of 90 days or more (Andriole, 1991; Naber, 1991; Childs, 1987; Paulson & White, 1978; Milingos et al., 1983) but there is no evidence that this is superior to 28 days.

It is difficult to make evidence based recommendations about treatment because most studies have small patient numbers, are non-comparative, define chronic bacterial prostatitis in different ways, have no placebo group, use different doses of the drug studied for different lengths of time, use different treatment outcomes and have different periods of follow-up. These recommendations are based on the studies available plus expert opinion.

Prostatic calculi have been suggested as a source for recurrent infection (Meares, 1987). They are extremely common radiographically (Ludwig et al., 1994; Peeling & Griffiths, 1984). Radical transurethral prostatectomy or total prostatectomy is effective in some patients if they are selected carefully (Barnes, Hadley, & O'Donoghue, 1982; Smart, Jenkins, & Lloyd, 1975).

Treatment for chronic abacterial prostatitis/chronic pelvic pain syndrome

There are no universally effective treatments for chronic abacterial prostatitis/chronic pelvic pain syndrome. The lack of knowledge of the etiology of these conditions means that no specific recommendations can be made and treatment choice is usually trial and error. There is currently a systematic review of therapies for chronic abacterial prostatitis/chronic pelvic pain syndrome taking place (McNaughton Collins, MacDonald, & Wilt, 2000).

Despite negative cultures most clinicians try antibiotics initially to cover occult infection. This may be effective in a number of patients (Brunner, Weidner, & Schiefer, 1993; Colleen & Mardh, 1975; Bergman, Wedren, & Holm, 1989; Thin & Simmons, 1983; Pavone-Macaluso, Di Trapani, & Pavone, 1991; Simmons & Thin, 1985) although this does not mean that the problem was genuinely infective. Treat as for chronic bacterial prostatitis with a quinolone or tetracycline.

Other treatments include:

- Transurethral microwave thermotherapy [(chronic abacterial prostatitis/chronic pelvic pain syndrome-inflammatory) (Level of Evidence Ib, Grade of Recommendation A)] (Nickel & Sorensen, 1996)
- Alpha Blockers:
    - Terazosin 2 to 10 mg for 28 days. The dose should be increased gradually according to symptomatic response (chronic abacterial prostatitis/chronic pelvic pain syndrome-inflammatory and non-inflammatory) (Level of Evidence Ib, Grade of Recommendation A) (Neal & Moon, 1994; Lacquaniti et al., 1999).
    - Alfuzosin 2.5 mg three times daily for 42 days in patients with confirmed urodynamic abnormalities (Level of Evidence Ib, Grade of Recommendation A) (De la Rosette et al., 1992).

- Non-steroidal anti-inflammatory drugs (chronic abacterial prostatitis/chronic pelvic pain syndrome-inflammatory). No specific non-steroidal anti-inflammatory drug can be recommended as the evidence base uses a drug not licensed in the United Kingdom (Level of Evidence III, Grade of Recommendation B) (Canale et al., 1993).
- Cernilton (pollen extract) probably acts as an anti-inflammatory. One tablet three times daily for 6 months (chronic abacterial prostatitis/chronic pelvic pain syndrome) (Level of Evidence III, Grade of Recommendation B) (Buck, Rees, & Ebeling, 1989; Rugendorf et al., 1993).
- The bioflavonoid, quercetin 500 mg twice daily for 28 days (chronic abacterial prostatitis/chronic pelvic pain syndrome-inflammatory and non-inflammatory) (Level of Evidence Ib, Grade of Recommendation A) (Shoskes et al., 1999).
- Stress management (Miller, 1988). No specific therapy has been tested or advocated although referral for psychological assessment may be appropriate in some (Level of Evidence IV, Grade of Recommendation C). Diazepam 5 mg twice daily for 90 days has produced symptomatic benefit (Thin & Simmons, 1983) although benzodiazepines are not recommended in clinical practice because of dependency.
- The role of allopurinol (chronic abacterial prostatitis/chronic pelvic pain syndrome) remains controversial (Persson, Rondquist, & Ekblon, 1996; Nickel, Siemens, & Lundie, 1996). A Cochrane Systematic Review, published in 1999, recommended that further studies are needed (McNaughton Collins & Wilt, 1999).

Sexual partners

Partner notification and empirical treatment is not required unless a specific sexually transmitted pathogen is found at initial screening. Management should be according to the guidelines for that specific infection.

Follow-up

Chronic prostatitis is a difficult to manage; relapsing conditions and patients are typically followed up for long periods of time. No specific follow-up recommendations can be made. The U.S. National Institutes of Health has produced a chronic prostatitis symptom index which can be used as a robust outcome measure (Litwin et al., 1999).

Definitions:

The following rating scheme was used for major management recommendations.

Levels of Evidence:

Ia

- Evidence obtained from meta-analysis of randomised controlled trials

Ib

- Evidence obtained from at least one randomised controlled trial

IIa

- Evidence obtained from at least one well designed controlled study without randomisation

IIb

- Evidence obtained from at least one other type of well designed quasi-experimental study

III

- Evidence obtained from well designed non-experimental descriptive studies such as comparative studies, correlation studies, and case control studies

IV

- Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Grading of Recommendations:

A (Evidence Levels Ia, Ib)

- Requires at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing the specific recommendation.

B (Evidence Levels IIa, IIb, III)

- Requires availability of well conducted clinical studies but no randomised clinical trials on the topic of recommendation.

C (Evidence Level IV)

- Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities.
- Indicates absence of directly applicable studies of good quality.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is graded and identified for select recommendations (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

When managed correctly, the prognosis of acute prostatitis is good, cure is likely, and chronic bacterial prostatitis may be prevented. Appropriate management of chronic prostatitis may result in symptom relief.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- It is difficult to make evidence based recommendations about treatment of chronic bacterial prostatitis because most studies have small patient numbers, are non-comparative, define chronic bacterial prostatitis in different ways, have no placebo group, use different doses of the drug studied for different lengths of time, use different treatment outcomes and have different periods of follow up. These guideline recommendations for chronic bacterial prostatitis are based on the studies available plus expert opinion.
- There are no universally effective treatments for chronic abacterial prostatitis/chronic pelvic pain syndrome. The lack of knowledge of the aetiology of these conditions means that no specific recommendations can be made and treatment choice is usually trial and error. There is currently a systematic review of therapies for chronic abacterial prostatitis/chronic pelvic pain syndrome.
- Chronic prostatitis is a difficult to manage; relapsing condition and patients are typically followed up for long periods of time. No specific follow up recommendations can be made.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The Clinical Effectiveness Group reminds the reader that guidelines in themselves are of no use unless they are implemented systematically. The following auditable outcome measures are provided:

- Treatment of acute prostatitis with an appropriate antibiotic for 28 days: target 90%
- Investigation of urinary tract following acute prostatitis: target 90%

- Treatment of chronic bacterial prostatitis with 28 days of an appropriate antibiotic: target 90%

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD). 2002 national guideline for the management of prostatitis. London: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD); 2002. Various p. [93 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1999 Aug (revised 2002)

GUIDELINE DEVELOPER(S)

British Association of Sexual Health and HIV - Medical Specialty Society

SOURCE(S) OF FUNDING

Not stated

GUIDELINE COMMITTEE

Clinical Effectiveness Group (CEG)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Authors: Paul Walker; Janet Wilson

Clinical Effectiveness Group (CEG) Members: Keith Radcliffe (Chairman); Imtyaz Ahmed-Jushuf; Jan Welch; Mark FitzGerald; Janet Wilson

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Conflicts of Interest: None

GUIDELINE STATUS

This is the current release of the guideline. This guideline updates a previously released version.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Available in HTML format from the Association for Genitourinary Medicine (AGUM) Web site. Also available in Portable Document Format (PDF) from the Medical Society for the Study of Venereal Diseases (MSSVD) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- UK national guidelines on sexually transmitted infections and closely related conditions. Introduction. Sex Transm Infect 1999 Aug;75(Suppl 1):S2-3.

Electronic copies: Available in Portable Document Format (PDF) from the Medical Society for the Study of Venereal Diseases (MSSVD) Web site.

The following is also available:

- Revised UK national guidelines on sexually transmitted infections and closely related conditions 2002. Sex Transm Infect 2002;78:81-2

Print copies: For further information, please contact the journal publisher, BMJ Publishing Group.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on December 8, 2000. The information was verified by the guideline developer on January 12, 2001. This summary was updated on June 24, 2002.

COPYRIGHT STATEMENT

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